

SURGERY FOR THE TREATMENT OF MORBID OBESITY - Page 1 of 2
INITIAL REPORT

Indiana State Department of Health
State Form 53321 (6-07)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

- ① Print firmly and neatly. ③ Fill in circles like this: ● ④ Print capital letters only
② Only use pens with blue or black ink. Not like this: ✗ ✓ and numbers completely
Mark mistakes like this: ✗ inside boxes. A 2 C 3

Section 1. Patient Information

Last Name

First Name

MI

Phone Number

Number & Street Address

City

State

ZIP Code

County

Date of Birth (mm/dd/yyyy)

Age (years)

Sex:
☐ Male ☐ Female ☐ Unknown

Ethnicity:
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race (select all that apply):
☐ Asian ☐ White
☐ Black or African American ☐ Other/Multiracial
☐ American Indian or Alaska Native ☐ Unknown
☐ Native Hawaiian or Other Pacific Islander

Section 2. Surgery Information

Baseline Measurements (before surgery):

BMI: _____ **Waist Circumference:** _____
Inches

Previous Abdominal Surgery? ☐ Yes ☐ No

Comorbidities:

ICD-9-CM Code

ICD-9-CM Code

ICD-9-CM Code

ICD-9-CM Code

ICD-9-CM Code

Surgery:

Date of Procedure (mm/dd/yyyy): _____

Surgical Diagnosis (ICD-9-CM Code): _____

Diagnosis, description:

Surgical Procedure (CPT Code): _____

Procedure, description:

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Section 2. Surgery Information (continued)

Name of Facility Where Surgery Performed

Facility Number & Street Address

City

State

ZIP Code

Telephone Number

FAX Number

Surgeon's Indiana License Number

Name of Surgeon

Address

City

State

ZIP Code

Telephone Number

FAX Number

Section 3. Additional Information and Comments

Comments:

Last Name of Person Completing Form

First Name of Person Completing Form

Phone Number

Date Form Completed (mm/dd/yyyy)